471-000-57 Nebraska Medicaid Billing Instructions for Home Health Agency Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for home health services are covered in 471 NAC 9-000. For a listing of billing instructions for all Medicaid services, see 471-000-49.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

Third Party Resources: Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, denial, or other documentation from the third party resource must be submitted with the claim. For instructions on billing Medicare crossover claims, see 471-000-70.

Verifying Eligibility: Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

CLAIM FORMATS

Electronic Claims: Home health services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Paper Claims: Home health services are billed to Nebraska Medicaid on Form CMS-1450, "Health Insurance Claim Form." Instructions for completing Form CMS-1450 are in this appendix.

Share of Cost Claims: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

CMS-1450 FORM COMPLETION AND SUBMISSION

Mailing Address: When submitting claims on Form CMS-1450, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Claim Example: See 471-000-51 for an example of Form CMS-1450.

Claim Form Completion Instructions: CMS-1450 (UB-92) completion requirements for Nebraska Medicaid are outlined below. The numbers listed correspond to the CMS-1450 form locators (FL) and are identified as required, situational, recommended or not used. Unlabeled form locators are not included in these instructions. For a summary of form locator requirements for all services, see 471-000-78.

These instructions must be used with the complete CMS-1450 (UB-92) claim form completion instructions outlined in the Nebraska Uniform Billing Data Element Specifications. The Nebraska Uniform Billing Data Element Specifications document is available from the Nebraska Uniform Billing Committee through the Nebraska Hospital Association.

FL	DATA ELEMENT DESCRIPTION	REQUIREMENT
1.	**Provider Name, Address & Telephone Number**	**Required**
3.	**Patient Control Number**	**Required**
	The patient control number will be reported on the Medicaid Remittance Advice.	
4.	**Type of Bill**	**Required**
5.	**Federal Tax Number**	**Recommended**

6. Statement Covers Period **Required**

Durable medical equipment rental must be billed on a separate claim from home health therapy/visit services. The statement covers period must reflect the rental period. For DME rental requirements, see 471 NAC 7-010.09.

7. Covered Days **Not Used**

8. Non-Covered Days **Not Used**

9. Coinsurance Days **Not Used**

10. Lifetime Reserve Days **Not Used**

12. Patient Name **Required**

The patient is the person that received services. When billing for services provided to the ineligible mother of an unborn child, enter the name of the mother (see 471 NAC 1-002.02K).

13. Patient Address **Recommended**

The patient is the person that received services.

14. Patient Birthdate **Required**

The patient is the person that received services.

15. Patient Sex **Required**

The patient is the person that received services.

16. Patient Marital Status **Not Used**

17. Admission/Start of Care Date **Required**

18. Admission Hour **Not Used**

19. Type of Admission/Visit **Not Used**

20. Source of Admission **Not Used**

21. Discharge Hour **Not Used**

22. Patient Status **Not Used**

23. Medical/Health Record Number **Required**

24-30. Condition Codes **Situational**

Use if applicable.

32-35. Occurrence Codes and Dates **Situational**

Required for traumatic diagnoses and claims for physical therapy, occupational therapy, and speech pathology. Use other occurrence codes if applicable.

36. Occurrence Span Code and Dates **Not Used**

37. Internal Control Number (ICN)/ Document Control Number (DCN) **Situational**

Required on adjustments.

38. Responsible Party Name and Address **Not Used**

39-41. Value Codes and Amounts **Situational**

Use if applicable.

42. Revenue Code **Required**

43. Revenue Description **Situational**

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required.

44. HCPCS/Rates/HIPPS Rate Codes **Required**

HCPCS procedure codes are required on all lines.

For home health visits, use the procedure codes and modifiers listed below. Each service/visit must be billed on a separate line.

Visits (two hours or less of uninterrupted direct client care in the home): Procedure code modifiers TD (registered nurse) and TE (licensed practical nurse) must be used with procedure code G0154:

G0151	Services of physical therapist, in home health setting, each 15 minutes
G0152	Services of occupational therapist, in home health setting, each 15 minutes
G0153	Services of speech therapist, in home health setting, each 15 minutes
G0154 TD	Services of skilled nurse in home health setting, each 15 minutes
G0154 TE	Services of skilled nurse, in home health setting, each 15 minutes
G0156	Services of home health aide, in home health setting, each 15 minutes

Extended Hours (shift work - continuous direct client care in the home of more than 2 hours duration):

S9122	Home health aide or certified nursing assistant, providing care in the home; per hour
S9123	Nursing care, in the home; by registered nurse, per hour
S9124	Nursing care, in the home; by licensed practical nurse, per hour

High Tech Extended Hours (shift work - continuous direct client care in the home of more than 2 hours duration): Procedure code modifier TG (high tech) is required.

S9123 TG	Nursing care, in the home; by registered nurse, per hour
S9124 TG	Nursing care, in the home; by licensed practical nurse, per hour

Ventilator Care: Procedure code TG (high tech) is required.

T1022 TG	Contracted home health agency services, all services provided under contract, per day

Special Contracted Services:

T1022	Contracted home health agency services, all services provided under contract, per day

For durable medical equipment, prosthetics, orthotics and allowable medical supplies, use the procedure codes and modifiers listed in the Nebraska Medicaid Practitioner Fee Schedule at 471-000-507. Up to four modifiers may be entered for each procedure code.

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required on, or as an 8½ x 11" attachment to, the claim. A copy of the invoice showing the provider's cost or manufacturer's suggested retail price is also required as an attachment to the claim.

Billing instructions and procedure codes for the following durable medical equipment are outlined in these instructions beginning on page 10 of this appendix.

Air Fluidized and Low Air Loss Beds
Apnea Monitors
Breast Pumps
Infusion Pumps, external
Neuromuscular Electrical Stimulators (NMES)
Oxygen and Oxygen Equipment
Parenteral Nutrition
Pressure Reducing Support Surfaces
Seat Lifts
Spinal Orthoses: Seating Systems, Back Modules
Transcutaneous Electrical Nerve Stimulators (TENS)
Vehicles, Power-Operated
Wheelchairs

45. Service Date **Situational**

Required on all lines of claims with claim date spans (FL6) greater than one calendar day.

46. Units of Service **Required**

Units of service must be reported as defined in the procedure code description. Units must be whole numbers. No decimals or fractions permitted.

For procedure codes G0151 – G0156, report units using the following table.

Units	Time	Units	Time
1	1 – 15 minutes	5	61 – 75 minutes
2	16 – 30 minutes	6	76 – 80 minutes
3	31 – 45 minutes	7	81 – 105 minutes
4	46 – 60 minutes	8	106 – 120 minutes

For procedure codes S9122 – S9124, report units using the following table:

Units	Time
3	2 hours, 30 minutes – 3 hours, 29 minutes
4	3 hours, 30 minutes – 4 hours, 29 minutes
5	4 hours, 30 minutes – 5 hours, 29 minutes
6	5 hours, 30 minutes – 6 hours, 29 minutes
7	6 hours, 30 minutes – 7 hours, 29 minutes
8	7 hours, 30 minutes – 8 hours, 29 minutes
9	8 hours, 30 minutes – 9 hours, 29 minutes
10	9 hours, 30 minutes – 10 hours, 29 minutes

For procedure code T1022 and T1022 TG, use 1 unit for each 21 to 24 hour time increment.

For durable medical equipment, prosthetics, orthotics and allowable medical supplies, review the procedure code description to determine if the item is billed per each, per pair, etc. For rental items, refer to Medicaid regulations at 471 NAC 7-010.09B for correct units of service for monthly and daily rental periods.

47. Total Charges (by Revenue Code Category) **Required**

Total charges must be greater than zero. Do not submit negative amounts. Enter the provider's customary charge for each procedure code. Each procedure code/line must have a separate charge.

48. Non-Covered Charges **Situational**

Enter only Nebraska Medicaid non-covered charges. Do not submit negative amounts.

50. Payer Identification **Not Used**

51. Provider Number **Required**

Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

52. Release of Information Certification Indicator **Not Used**

53. Assignment of Benefits Certification Indicator **Not Used**

54. Prior Payments - Payers and Patient **Situational**

Enter any payments made, due, or obligated from other sources for services listed on this claim unless the source is from Medicare. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached to each claim when submitting multiple claim forms.

DO NOT enter previous Medicaid payments, Medicaid copayment amounts, Medicare payments, or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount).

55. Estimated Amount Due **Not Used**

58. Insured's Name **Required**

When billing for services provided to the ineligible mother of an eligible unborn child, enter the name of the unborn child as it appears on the Nebraska Medicaid Card or Nebraska Health Connection ID Document.

59. Patient's Relationship to Insured **Required**

Use patient relationship code 18 for all claims.

60. Certificate/Social Security Number/Health Insurance Claim/Identification Number **Required**

Enter the Medicaid client's complete eleven-digit identification number (example: 123456789-01). When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child.

61. Insured Group Name **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

62. Insurance Group Number **Situational**

Recommended when Nebraska Medicaid is the secondary payer.

63. Treatment Authorization Code **Situational**

Required for services prior authorized by Nebraska Medicaid. Do not complete when the authorization is issued by the Medicaid managed care plan Primary Care +.

64. Employment Status Code of the Insured **Not Used**

65. Employer Name of the Insured **Not Used**

66. Employer Location of the Insured **Not Used**

67. Principal Diagnosis Code **Required**

The COMPLETE diagnosis code is required. A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM.

68-75. Other Diagnosis Codes--ICD-9-CM **Situational**

Required if more than one diagnosis applies to the services on this claim.

76. Admitting Diagnosis/Patient's Reason for Visit **Not Used**

77. External Cause of Injury Code (E-Code) **Situational**

Required if the principal diagnosis is trauma.

79. Procedure Coding Method Used **Not Used**

80. Principal Procedure Code and Date **Not Used**

81. Other Procedure Codes and Dates **Not Used**

82. Attending Physician ID **Required**

The practitioner license number must begin with the two-digit state abbreviation followed by the state license number (example: NE123456).

Enter the attending practitioner's last and first name.

83. Other Physician ID **Not Used**

84. Remarks **Situational**

Use to explain unusual services and to document medical necessity. For durable medical equipment and medical supplies, enter the numeric initial rental date for each rental item. For more than one rental, enter the line number, followed by the initial rental date.

85. Provider Representative Signature **Required**

The provider or authorized representative must sign the claim form. A signature stamp, computer-generated, or typewritten signature will be accepted.

86. Date Bill Submitted **Required**

The signature date must be on or after the last date of service listed on the claim.

Claim Attachments: A copy of the invoice showing the provider's cost or manufacturer's suggested retail price must be attached to the claim for all services billed with miscellaneous and not otherwise classified (NOC) procedure codes.

Billing Instructions and Procedure Codes for Durable Medical Equipment:

Use of procedure codes, procedure code modifiers, and other billing requirements for the following DME and supplies are included in this section -

Air Fluidized and Low Air Loss Beds
Apnea Monitors
Breast Pumps
Infusion Pumps, External
Neuromuscular Electrical Stimulators (NMES)
Oxygen and Oxygen Equipment
Parenteral Nutrition
Pressure Reducing Support Surfaces
Seat Lifts
Spinal Orthoses: Seating Systems, Back Modules
Transcutaneous Electrical Nerve Stimulators (TENS)
Vehicles, Power-Operated
Wheelchairs

Air Fluidized and Low Air Loss Bed Units

Medicaid pays for air fluidized and low air loss bed units on a rental basis for a maximum period of 20 weeks for active healing and treatment of stage III and stage IV pressure ulcers located on the trunk or pelvis, while progressive and consistent wound healing occurs. (There is also coverage of these types of beds for a maximum period of eight weeks from the date of surgery for post-operative healing of major skin grafts or myocutaneous flaps on the trunk or pelvis. These products are covered only for treatment of stage III and stage IV pressure ulcers, require a Coordination Plan, and are not covered for "prevention" purposes.)

Use procedure code modifier RR or KR.

E0193 Powered air flotation bed (low air loss therapy)
Note: E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which is characterized by all of the following:

1. An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;
2. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater;
3. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;
4. A surface designed to reduce friction and shear;
5. Can be placed directly on a hospital bed frame; and
6. Automatically re-adjusts inflation pressures with change in position of bed (e.g., head elevation, etc.).

E0194 Air fluidized bed
Note: E0194 describes a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.

Apnea Monitors

Equipment

Requires coordination plan.

Use procedure code modifier RR, KR, or MS.

E0618 Apnea monitor

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A9900 Apnea monitor supplies - one month supply
Note: An apnea monitor supply kit (A9900) includes lead wires, belts, and if electrodes used: any type electrodes, conductive paste or gel, tape or other adhesive, adhesive remover and skin prep materials. One unit of service represents apnea monitor supplies needed for one month. Supplies must be billed along with monitor rental. Provide description and invoice.
E1399 Equipment and supplies required for pneumocardiogram
Note: Combine charges for equipment and supplies required for pneumocardiogram and bill as a single service. Provide description and invoice.

Breast Pumps

Use procedure code modifier NU, RR, KR, UE, LL, or MS (E0604 only).

E0602 Breast pump, manual, including all accessories
E0603 Breast pump, battery operated, with electric adapter and all accessories
E0604 Breast pump, electric, including all accessories (rental only) (Note: Purchase of one breast pump kit is allowed. Use procedure code A9900 and bill with pump rental. Include a complete description and invoice.)

Infusion Pumps, External

Procedure code K0455 is not valid for Nebraska Medicaid. Use procedure code E0781 or E0791.

Supplies/Accessories

A4221 Supplies for maintenance of drug infusion catheter, per week
Note: Supplies for catheter (i.e., PICC, central venous, etc.) maintenance must be bundled under code A4221. This code includes all catheter maintenance items, such as dressings, tape, topical antibiotics and antiseptics, needles, syringes and flush solutions (normal saline, heparin). Other codes should not be used for separate billing of these supplies. One unit of service is allowed for each week of covered therapy.

A4222 Supplies for external drug infusion pump, per cassette or bag
Note: Supplies for drug administration must be bundled under code A4222. This code includes all supplies necessary for drug administration such as the bag, cassette or other reservoir for the drug, diluting solutions, tubing, needles, syringes, port caps, antiseptics, compounding and preparation charges. Other codes should not be used for separate billing of these supplies. One unit of service is allowed for each bag/cassette/reservoir prepared.

A4649 Disinfectant cleaning solution for bacteria control, concentrate. (Note: Provide description and invoice).

A4649 Disinfectant cleaning solution kit including disinfectant, container with lid and measuring cup, each kit (provide description and invoice).

Neuromuscular Electrical Stimulators (NMES)

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4557 Lead wires (e.g., apnea monitor)

E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)

A4595 NMES supplies – one month supply
Note: A NMES supply kit includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used). One unit of service represents supplies needed for one month for a NMES, daily use. If the NMES unit is used less than daily, the frequency of billing for the NMES supply code must be reduced proportionally.

Oxygen and Oxygen Equipment

Equipment

Use procedure code modifier QE, QF, or QG, if applicable. If not applicable, use procedure code modifiers RR or KR. When billing, units of service must reflect the number of months rental or the number of days rental. Do not use the lb\cubic feet units.

E0424 Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0431 Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434 Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439 Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E1390 Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate

Contents

Procedure code descriptions indicate when contents may be billed in addition to the oxygen delivery system. Use procedure code modifier QE, QF or QG, if applicable. If not applicable, use procedure code modifier NU. Bill oxygen contents on a monthly basis, not daily or weekly. Unit of service must be "1." Do not use the lb/cubic feet units.

E0441 Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)
E0442 Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned)
E0443 Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used)
E0444 Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used)

Replacement Supplies/Accessories

The following supplies/accessories are covered as replacement for client-owned oxygen equipment only and CANNOT be billed in addition to the equipment at the time of purchase or with rented equipment. Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4608 Transtracheal oxygen catheter, each
A4615 Cannula, nasal
A4616 Tubing (oxygen), per foot
A4619 Face tent

A4620 Variable concentration mask
A7525 Tracheostomy mask
E0455 Oxygen tent, excluding croup or pediatric tents
E0550 Humidifier, durable for extensive supplemental humidification during IPPB treatment or oxygen delivery
E0555 Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560 Humidifier, durable for supplemental humidification during IPPB treatments or oxygen
E0580 Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353 Regulator
E1355 Stand/rack

Parenteral Nutrition

Nutrients

When homemix parenteral nutrition solutions are used, the component carbohydrates (B4164, B4180), amino acids (B4168-B4178), additive (B4216), and lipids (B4184, B4186) are all separately billable. When premix parenteral nutrition solutions are used (B4189-B4199, B5000- B5200) there must be no separate billing for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids are separately billable with premix solutions.

For codes B4189-B4199, one unit of service represents one day's supply of protein and carbohydrate regardless of the fluid volume and/or the number of bags. For example, if 60 grams of protein are administered per day in two bags of a premix solution each containing 30 grams of amino acids, correct coding is one (1) unit of B4193, not two units of B4189.

Parenteral nutrition solutions containing less than 10 grams of protein per day are coded using procedure code B9999.

For codes B5000-B5200, one unit of service is one gram of amino acid.

Pressure Reducing Support Surfaces

Equipment

Use procedure code modifier NU, RR, KR, UE or LL.

E0180 Pressure pad, alternating with pump
E0181 Pressure pad, alternating with pump, heavy duty
E0182 Pump for alternating pressure pad

E0184 Dry pressure mattress

Note: E0184 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Foam height of 5 inches or greater;
2. Foam with a density and other qualities that provide adequate pressure reduction;
3. Durable, waterproof cover; and
4. Can be placed directly on a hospital bed frame.

E0185 Gel or gel-like pressure pad for mattress, standard mattress length and width

Note: E0185 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by a gel layer with a height of 2 inches or greater.

E0186 Air pressure mattress

Note: E0186 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Height of 5 inches or greater of the air layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0187 Water pressure mattress

Note: E0187 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Height of 5 inches or greater of the water layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0188 Synthetic sheepskin pad

E0189 Lambswool sheepskin pad, any size

E0196 Gel pressure mattress

Note: E0196 describes a nonpowered pressure reducing mattress. It is characterized by all of the following:

1. Height of 5 inches or greater of the gel layer;
2. Durable, waterproof cover; and
3. Can be placed directly on a hospital bed frame.

E0197 Air pressure pad for mattress, standard mattress length and width

Note: E0197 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.

E0198 Water pressure pad for mattress, standard mattress length and width

Note: E0198 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by a filled height of 3 inches or greater.

E0199 Dry pressure pad for mattress, standard mattress length and width

Note: E0199 describes a nonpowered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress. It is characterized by all of the following:

1. Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay;

2. Foam with a density and other qualities that provide adequate pressure reduction; and
3. Durable, waterproof cover.

E0370 Air pressure elevator for heel

E0371 Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width

Note: E0371 describes an advanced nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;
2. Total height of 3 inches or greater;
3. A surface designed to reduce friction and shear; and
4. Documented evidence to substantiate that the product is effective for the treatment of Stage III or IV pressure ulcers on the trunk or pelvis.

E0373 Nonpowered advanced pressure reducing mattress

Note: E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

1. Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;
2. Total height of 5 inches or greater;
3. A surface designed to reduce friction and shear;
4. Documented evidence to substantiate that the product is effective for the treatment of Stage III or IV pressure ulcers on the trunk or pelvis; and
5. Can be placed directly on a hospital bed frame.

Replacement Supplies/Accessories

The following supplies/accessories are covered as replacement for client-owned alternating pressure pads only and CANNOT be billed in addition to the equipment at the time of purchase or with rented equipment. Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4640 Replacement pad for use with medically necessary alternating pressure pad owned by patient

Note: Medicaid does not cover air-powered mattress overlays and mattress replacements, such as products coded E0277.

Seat Lifts

Use procedure code modifier NU, RR, KR, UE or LL.

*E0627 Seat lift mechanism incorporated into a combination lift-chair mechanism
Note: Use E0627 only when billing Medicaid for seat lift chairs for individuals that are not eligible for Medicare Part B. This code describes a seat lift chair with seat lift mechanism.
*E0628 Separate seat lift mechanism for use with patient owned furniture - electric
*E0629 Separate seat lift mechanism for use with patient owned furniture - non-electric
E1399 Seat lift chair excluding the Medicare-approved seat lift mechanism
Note: Use E1399 only when billing Medicaid for the chair portion of a seat lift chair when Medicare approved the seat lift mechanism. The Medicare EOMB showing approval of the seat lift mechanism must be submitted with the claim when billing Medicaid.

*Requires prior authorization.

Spinal Orthoses: Seating Systems, Back Modules

A prefabricated back seating module which is incorporated into a wheelchair base is coded using the wheelchair back accessory codes (K0023, K0024, or K0108). See Wheelchair Options/Accessories.

Devices which are described under procedure codes K0115 and K0116 should not be billed using other spinal orthosis codes (L0300-L0440, L0500-L1499).

For procedure codes K0115 and K0116, use procedure code modifier NU, RR, KR, UE, or LL.

*K0115 Seating system, back module, posteriorlateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base.
Note: K0115 describes an orthosis which is individually made for a specific patient from his/her measurements and/or pattern. It includes a back module with is molded to a patient model. This orthosis is incorporated into a wheelchair base.
*K0116 Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base
Note: K0116 describes an orthosis which is similar to K0115 except that a seat module is fully incorporated into the item. This orthosis is incorporated into a wheelchair base.

*Requires prior authorization.

Transcutaneous Electrical Nerve Stimulators (TENS) and Related Supplies

Supplies/Accessories

Use procedure code modifier RP if the supply/accessory is used with equipment OWNED by the client.

A4557 Lead wires, (e.g., apnea monitor)
A4595 TENS supplies, 2 lead, per month
Note: A4595 includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used). One unit of service represents supplies needed for one month for a two-lead TENS, assuming daily use. For four-lead tens, bill two units, assuming daily use. If the TENS unit is used less than daily, the frequency of billing for the TENS supply code must be reduced proportionally.
E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)

Vehicles, Power-Operated (POV)

Use procedure code modifier NU, RR, KR, UE or LL.

*E1230 Power operated vehicle (three or four wheel, non-highway)
Note: E1230 should be used only for POV's that can be operated inside the home. Vehicles that are generally intended for use outdoors because of their size and/or other features are not eligible for coverage.

*Requires prior authorization.

WheelChairs (**Manual and Power)**

Use procedure code modifier NU, RR, KR, UE or LL.

*K0001 Standard wheelchair
Weight: > 36 lbs.
Seat Width: 16" (Narrow), 18" (Adult)
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed or detachable
Footplate Extension: 16"-17"
Footrests: Fixed or swingaway detachable
*K0002 Standard hemi (low seat) wheelchair
Weight: > 36 lbs.
Seat Width: 16" (Narrow), 18" (Adult)
Seat Depth: 16"
Seat Height: 17"-18"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed or detachable
Footplate Extension: 14"-17 1/2"
Footrests: Fixed or swingaway detachable

*K0003 Lightweight wheelchair
Weight: ≤ 36 lbs.
Seat Width: 16" or 18"
Seat Depth: 16"
Seat Height: ≥ 17" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Height: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0004 High strength, lightweight wheelchair
Lifetime warranty: on side frames and crossbraces
Weight: < 34 lbs.
Seat Width: 14", 16", or 18"
Seat Depth: 14" (child), 16" (adult)
Seat Height: ≥ 17" and < 21"
Back Height: Sectional or adjustable 15"-19"
Arm Style: Fixed or detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0005 Ultralightweight wheelchair
Lifetime warranty: on side frames and crossbraces
Weight: < 30 lbs.
Adjustable rear axle position
Seat Width: 14", 16", or 18"
Seat Depth: 14" (child), 16" (adult)
Seat Height: ≥ 17" and < 21"
Arm Style: Fixed or detachable
Footplate extension: 16"-21"
Footrests: Fixed or swingaway detachable

*K0006 Heavy duty wheelchair
Seat Width: 18"
Seat Depth: 16" or 17"
Seat Height: > 19" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-17"
Footrests: Fixed or swingaway detachable
Reinforced back and seat upholstery
Can support patient weighing > 250 pounds

*K0007 Extra heavy duty wheelchair
Seat Width: 18"
Seat Depth: 16" or 17"
Seat Height: > 19" and < 21"
Back Height: Non-adjustable 16"-17"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
Reinforced back and seat upholstery
Can support patient weighing > 300 pounds

*K0009 Other manual wheelchair/base
*K0010 Standard-weight frame motorized/power wheelchair
Seat Width: 14"-18"
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
*K0011 Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking.
Seat Width: 14"-18"
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
*K0012 Lightweight portable motorized/power wheelchair
Seat Width: 14"-18"
Seat Depth: 16"
Seat Height: ≥ 19" and ≤ 21"
Back Height: Sectional 16" or 18"
Arm Style: Fixed height, detachable:
Footplate Extension: 16"-21"
Footrests: Fixed or swingaway detachable
Weight: < 80 lbs. without battery
Folding back or collapsible frame
*K0014 Other motorized/power wheelchair base

*Requires prior authorization.

Wheelchair Options/Accessories

Use procedure code modifiers NU, RR, or KR to indicate option/accessory provided with wheelchair base at initial issue. Do not bill for options/accessories included in base price.

Use modifier KA for add on option/accessory for wheelchair (at other than initial issue). Requires prior authorization.

Use modifier RP for replacement and repair (Use to indicate replacement of option/accessory for client-owned wheelchairs which have been in use for some time.) Prior authorization not required.